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Research and Training Center on Community Living • Institute on Community Integration (UCEDD)

Problems in Defining Mental Retardation and Developmental Disability: Using the National Health Interview Survey

Introduction

In the April 2000 *MR/DD Data Brief* entitled, “Prevalence of Mental Retardation and/or Developmental Disabilities: Analysis of the 1994/1995 NHIS-D” (Larson et al., 2000), mental retardation (MR) and developmental disability (DD) were operationally defined using data from the 1994-1995 National Health Interview Survey on Disability (NHIS-D).

Clearly, the operational definition based on the current NHIS questions and procedures seriously underestimates the MR/DD population.

The NHIS-D was an unprecedented *ad hoc* survey on disability conducted as a supplement to the National Health Interview Survey (NHIS). It provided detailed information on a wide range of matters related to disabilities, including MR/DD. That information enabled Larson

et al. (2000), based on statutory and programmatic definitions in use at the time, to make their statistics directly relevant to policy issues. Using that definition, the authors estimated statistics on the prevalence of MR and/or DD in the U.S. household population, and in subsequent briefs reported a wide range of economic, social, health, and other outcomes and supports among NHIS-D sample members identified as having MR or DD (Larson et al., 2000; Larson,

About This *Data Brief*

This *DD Data Brief* represents a second look at the 1997-2004 National Health Interview Survey (NHIS) and its usefulness in describing the characteristics and needs of persons with intellectual or developmental disabilities (ID/DD) in the non-institutionalized U.S. population. The issue describes our attempt to create an operational definition of intellectual and developmental disability using the NHIS surveys.

This issue is co-authored by Gerry Hendershot, who retired from the National Center on Health Statistics and is now a private consultant, and Sheryl A. Larson, K. Charlie Lakin and Robert Doljanac from the Research and Training Center on Community Living, Institute on Community Integration, University of Minnesota.



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Lakin, Anderson, & Kwak, 2001a; Larson, Lakin, Anderson, & Kwak, 2001b; Larson, Lakin, Kwak, & Anderson, 2001c; Larson, Lakin, & Huang, 2003).

The NHIS-D has not been repeated and there are no plans to repeat it. Furthermore, no other national disability survey of comparable size and scope is planned. That means that there is no source of data, existing or planned, with which the decade-old statistics produced by Larson et al. (2000) can be updated. In the absence of a data source comparable to the NHIS-D, it is necessary to consider whether another data source can be used to produce *any* useful national statistics on MR/DD, even though they may not have the definitional precision and program relevance of the estimates by Larson et al. The ongoing NHIS is a logical candidate for such a substitute data source because throughout its history it has routinely collected *some* information on disability, including MR/DD.

The NHIS undergoes periodic revision of its content and procedures. The most recent revision was first fielded in 1997 and has remained basically unchanged since then. The purpose of the work reported here was to determine if the current version of the NHIS can produce useful estimates of MR/DD statistics, and to identify ways in which the NHIS could be revised to improve such estimates.

The National Health Institute Survey

The NHIS is conducted annually by the National Center for Health Statistics using interviewers who are recruited, trained, and supervised by the U.S. Bureau of the Census. The sample of households for the NHIS is randomly selected to represent the civilian, noninstitutionalized population of the United States. A new sample is selected each year and sample households are usually interviewed only once. Each year interviews are completed in about 40,000 households and information is collected on about 100,000 persons in those households. The data are collected in 60-minute, face-to-face interviews in sample households using standardized questionnaires.

Since 1997 the NHIS questionnaires have consisted of three core modules that are unchanged from year to year, and one or more supplemental modules that may differ from year to year. For purposes of estimating MR/DD statistics, it was decided to focus on the core modules so that estimates could be made annually and data from adjacent years could be aggregated to create larger, more statistically reliable samples. The annual core modules are:

- (1) a family questionnaire that obtains information about all members of the sample household from any knowledgeable adult member of the household;
- (2) a sample adult questionnaire that obtains additional information about one randomly-selected adult (18 or older) by self-response from that person; and
- (3) a sample child questionnaire that obtains information about one randomly-selected child or youth (17 or under) from an adult knowledgeable about the health of the child or youth.

The topics covered by the annual core modules include limitation of activity due to a physical, mental, or emotional problem; intentional and unintentional injuries; health insurance coverage; access to health care; health care utilization; medical conditions and symptoms; health-related behaviors; immunizations; AIDS risk and testing; and social and economic characteristics.

The questions are stored on a laptop computer that the interviewer takes to the sample household. Responses to questions are entered directly into the computer during the interview. After the interview, interviewers electronically transmit the completed interviews to the census bureau, which aggregates them into electronic files that are transmitted to the National Center for Health Statistics. The center edits the data to eliminate illogical or erroneous entries and prepares annual public-use microdata files that are stripped of information that would identify sample persons.

Health analysts can download the public use microdata files from a center Web site at no cost.

There were two considerations in deciding whether to use the family core questionnaire or the questionnaires for sample children and sample adults for estimating prevalence of MR/DD: the amount of information in each source, and the size of the samples for each. With respect to the amount of information, the family core questionnaire asks about limitations in a number of specific activities: walking, cognition, activities of daily living, instrumental activities of daily living, play (children only), school (children only), and work (adults only). For persons reported to have any of these limitations, questions are asked about the conditions causing the limitations, with specific mention of birth defect, mental retardation, and other developmental problems; also, the length of time since the onset of the condition is obtained.

The sample child questionnaire adds a number of items potentially useful in defining MR, including a direct question about MR, a positive response to which would be sufficient in itself to classify a child as having MR using the Larson et al. (2000) criteria. The child questionnaire also has direct questions about several conditions related to MR: cerebral palsy, autism, Down syndrome, epilepsy, and spina bifida. Larson et al. used conditions data to define a child as having MR if they had: (a) any of the related conditions *and* (b) a diagnosis of “learning disability” *and* (c) a “significant functional limitation in learning.” The sample child questionnaire has data on the first two criteria, but not the third, so the related condition-inclusion rules could be only imperfectly applied. Thus, the principal useful information added by the child questionnaire is the direct question on MR. Against this must be weighed the fact that the sample size for the child questionnaire is only about 13,000 per year, compared to about 28,000 children included in the family questionnaire.

The sample adult questionnaire adds relatively little useful information to that available from the family questionnaire. There are no direct questions about MR or conditions

typically related to MR. There are questions about limitations in a number of functions not on the family questionnaire, such as standing, stooping, grasping, and carrying, with follow-up questions about the underlying conditions (including “mental retardation”) and durations of those limitations. Again, the additional information available from the adult questionnaire must be weighed against the smaller sample size – about 33,000 adults compared to 73,000 adults in the sample for the family questionnaire.

To summarize, the family questionnaire provides more useful information about MR/DD than the sample child and sample adult questionnaires, and the family questionnaire provides more sample cases per year – 73,000 adults and 28,000 children, compared to 33,000 adults and 13,000 children in the sample questionnaires. Because of their smaller samples, the sampling errors of estimates based on the sample child and sample adult data are larger than those based on the family data. This is a crucial consideration when estimating statistics for the relatively small MR/DD population, and favors using the larger sample available from the family core questionnaire. For these reasons, it was decided to first explore use of the family questionnaire data as a basis for estimating the prevalence of MR/DD. As more data years of the post-1996 NHIS are released, it would be desirable to test the use of the child and adult sample questionnaire items (along with the family questionnaire data for the same sample persons) to define MR and DD, using pooled data from several years to reach an acceptable sample size.

Mental Retardation

Using the NHIS-D, Larson et al. (2000) classified a person as having mental retardation if any of the following were reported by the respondent in an interview:

1. In answer to a direct question about mental retardation, the person was reported to *have* mental retardation.

2. The person was reported to have a *limitation* in a *general* activity (such as play, school, or work) that was *caused* by mental retardation.

3. The person was reported to have a *limitation* in any of a long list of *specific* activities (such as communicating, bathing, shopping, etc.) that was *caused* by mental retardation.

4. The person was reported to have received *medical services* because of mental retardation.

5. The person was reported to have a *medical condition* associated with mental retardation (such as spina bifida, cerebral palsy, etc.) *and* a *learning disability* (in response to a direct question about learning disability) *and* a significant functional *limitation in learning* (such as serious difficulty learning). Note that all three conditions must have been present together to result in a classification of mental retardation using this criterion.

Based on this definition, Larson et al. estimated that 2,032,000 persons or 0.78% of the household population had mental retardation in 1994-1995.

Larson et al. (2000) had a large number of indicators of mental retardation available in the NHIS-D, which enabled them to construct an operational definition with considerable subtlety and refinement. In contrast, the current version of the NHIS family module has much less information. In fact, the current NHIS has only one question that allows identification of persons with mental retardation. Furthermore, the question is only asked about persons who have already been reported to be limited in play, school, work, self-care, walking, or remembering, or to be limited in “any other way,” because of a physical, mental, or emotional problem. For persons limited in any of these ways, the following question is asked: “What conditions or health problems cause {subject’s name} limitations?” To assist respondents in answering the question, they are handed a card on which is printed a list of possible responses, including “mental retardation.” (This list of conditions is different for children and adults, but both include mental retardation.)

It should be noted that the question about the causes of a limitation was not asked about *each* limitation reported, but about *all* limitations reported, taken collectively. That means that if a person was reported to have more than one limitation, a condition reported to be a cause of their “limitations” cannot be linked to a particular limitation.

If a report of mental retardation as a cause of a limitation in activity is taken as the NHIS operational definition of mental retardation, it is roughly comparable to the Larson et al. (2000) criteria 2 or 3 above, although Larson et al. had more information available to assess those criteria. Not included in the simple definition possible with the current NHIS are the Larson et al. criteria 1, 4, and 5: direct report of mental retardation, receiving services for mental retardation, and having selected MR/DD-related medical conditions and significant learning disabilities. Because of these omissions, it might be expected that the operational definition possible with the current NHIS would yield lower estimates of the prevalence of mental retardation. That is in fact the case: using the year 2000 NHIS and the one-question definition, about 743,000 persons are estimated to have had mental retardation, only about one-third of the 2,032,000 estimated by Larson et al. in 1994-1995. Clearly, the operational definition based on the current NHIS questions and procedures seriously underestimates the MR/DD population.

Developmental Disability

Although they overlap, mental retardation and developmental disability are different concepts. A person who has one of the impairments may or may not have the other. Basing their decisions on the statutory definition of developmental disability, Larson et al. (2000) developed an operational definition of developmental disability that they summarize as follows:

A multistage process was used to identify individuals with developmental disabilities. The process involved using NHIS-D variables to construct operational definitions for each of the seven areas of functional limitation in

the federal developmental disabilities definition: (a) self-care, (b) expressive or receptive language, (c) learning, (d) mobility, (e) self-direction, (f) capacity for independent living, and (g) economic self-sufficiency. The initial operational definitions were revised following review by a panel of experts in disability research. As conveyed in the DD Act, separate definitional approaches were required for persons 5 years and older and for children from birth to 5 years....

People 5 years and older were considered to have a developmental disability if they had substantial limitations... in three or more of the seven “areas of major life activity” expected to endure at least 12 months, with a limitation in at least one of these areas occurring before age 22 (p. 241).

Using this definition with the NHIS-D, Larson et al. estimated that there were 2,942,000 persons with DD, or 1.18% of the noninstitutionalized population in 1994-1995.

As with mental retardation, the NHIS-D provided sufficient information to operationally define DD in a way that is very consistent with statutory and programmatic definitions, but the NHIS for 1997 and later has far less information to work with. With regard to the “areas of major life activity,” the available NHIS items in the family core module are shown in Table 1. For three of the activities no data are available from the NHIS – expressive/receptive language, learning, and self-direction. (Table 1 also shows additional items measuring life activities that would be available if data from the sample child and sample adult questionnaires were used.)

The remaining four activities – self-care, mobility, capacity for independent living, and economic self-sufficiency – are measured in the NHIS by questions roughly similar in intent to those in the NHIS-D, although there were more such items in the NHIS-D. Another difference between the NHIS questions and the NHIS-D questions should be noted: the NHIS questions on self-care and independent living use “needing help from another person” as the criterion for a *significant* limitation, whereas the Larson et al. (2000) used “diffi-

culty” or “inability” to perform the activity as the criterion for a significant limitation.

For persons reported to be limited in any of the four measured major life activities, the number of years since the onset of the condition causing the limitation was obtained. By subtracting that number from the person’s current age (in years), an estimate of the age at onset of the condition was obtained. To be included as DD, the condition must have had its onset at age 22 or earlier. Note that the age at onset is for the condition *causing* the limitation, not the limitation itself. Because some conditions may not cause a limitation for some time after their onset, using age at onset of the condition as an indicator of age at onset of the limitation may result in including some persons in the DD population who would not have been according to the Larson et al. (2000) definition.

Following the statutory definition, Larson et al. (2000) classified persons aged 5 years or younger as having DD or not according to whether or not they had a medical condition consistently associated with DD in older persons or had a reported developmental delay. Comparable information is not available from the current NHIS family questionnaire.

Larson et al. (2000) classified a person as having DD only if they had significant limitations in at least three of the seven major life activities identified in DD legislation and measured by the NHIS-D. As just noted, the NHIS measures only four of the seven major life activities, and is not as inclusive in the four measured activities as were the Larson et al. measures of those activities. In the NHIS-D it was estimated that 67% of adults with DD have substantial limitations in self-direction and 48% have substantial limitations in communication. It might be expected, therefore, that operationally defining DD in the NHIS as having limitations in at least three of the four measured major life activities would result in lower estimates of the prevalence of DD than those reported by Larson et al. That is in fact the case: Whereas Larson et al. estimated that 2,942,000 persons had DD in 1994-1995, the estimate based on the year 2000 NHIS is only 224,000 persons, less than one-tenth the size of

Table 1. Major Life Activities, Related Family Core Questionnaire Items, Related Additional Sample Adult and Sample Child Questionnaire Items, and Universe of People About Which of the Questions Were Asked		
Major Life Activity	Related NHIS Question	Universe
Family Core Questionnaire Items		
Self-care	Because of a physical, mental, or emotional problem, {do/does} {you/anyone in the family} need the help of other persons with PERSONAL CARE NEEDS, such as eating, bathing, dressing, or getting around inside this home?	GE 3 years
Expressive/receptive language	None	NA
Learning	{Are/is} {you/anyone in the family} LIMITED IN ANY WAY because of difficulty remembering or because {you/they} experience periods of confusion? <u>OR</u> Classified as having mental retardation using the definition given earlier in this paper?	All ages
Mobility	Because of a health problem, {do/does} {you/anyone in the family} have difficulty walking without using any special equipment?	All ages
Self-direction	None	NA
Capacity for independent living	Because of a physical, mental, or emotional problem, {do/does} {you/anyone in the family} need the help of other persons in handling ROUTINE NEEDS, such as everyday household chores, doing necessary business, shopping, or getting around for other purposes?	GE 18 years
Economic self-sufficiency	Does a physical, mental, or emotional problem NOW keep {you/ anyone in the family/any of these family members} {(READ NAME BELOW)} from working at a job or business? Other than the persons mentioned, are any of {these family members/you/(READ NAMES BELOW)} limited in the type OR amount of work {you/they} can do because of a physical, mental or emotional problem?	GE 18 years
Additional Items from Sample Adult Questionnaire		
Mobility	By yourself, and without using any special equipment, how difficult is it for you to ... Walk a quarter of a mile – about 3 city blocks?	GE 18 years
Capacity for independent living	By yourself, and without using any special equipment, how difficult is it for you to ... Go out to things like shopping, movies, or sporting events? Participate in social activities such as visiting friends, attending clubs and meetings, going to parties...?	GE 18 years
Additional Items from Sample Child Questionnaire		
Learning	Has a representative from a school or a health professional ever told you that the child/youth had a learning disability?	3-17 years
Learning	Has a doctor or health professional ever told you that the child/youth had mental retardation? Autism?	LE 17 years

the earlier estimate. Clearly, the questions and procedures in the current NHIS seriously underestimate the size of the DD population.

Explaining Underestimates of MR/DD in the NHIS

In general, the main reason estimates of MR/DD are lower in the post-1996 NHIS family core module than the estimates from the NHIS-D is that far fewer questions are asked in the NHIS about MR and DD. It is an axiom of interview survey research that if more questions are asked about a circumstance or condition, it is more likely that information about that circumstance or condition will be elicited from respondents. Asking fewer questions about MR/DD in the current NHIS (compared to the NHIS-D) results in fewer reports of MR/DD. The questions *not* asked in the current NHIS family questionnaire that *were* asked in the NHIS-D can be described in summary as follows:

1. Direct questions about whether or not family members have mental retardation or developmental disabilities.
2. Questions about the causes of performance limitations in a long list of specific activities.
3. Questions about the health problems for which health care services were used.
4. Direct questions about selected health problems often related to mental retardation or developmental disability.
5. Questions about the major life activities: “use of expressive/receptive language”, “learning”, and “self-direction.”

The NHIS annual core questionnaire never posed all, or even most, of these questions. In the period 1982 through 1996, for instance, the core questionnaire asked one question about whether or not any family member had “mental retardation” and also asked for the main condition causing any reported limitation in activity, which could have been coded as “mental retardation.” Although that is not much information, the resulting estimates of the prevalence of MR were within reason. In the

most recent publication that reported estimates of mental retardation (Collins, 1997), the number of people with MR was estimated to be 1,562,000. That estimate, which was based on the direct question about MR in the family, is more than twice the estimate from the year 2000 NHIS (743,000), which was based on answers to the question about the cause of any limitation in activity. The reported estimate for 1990-1992 still falls short of the Larson et al. (2000) estimate for 1994-1995 (2,032,000), but it is much closer than the year 2000 estimate.

Two of the major goals of the NHIS redesign implemented in 1997 were to substantially reduce the average length of interview for the annual core questionnaire while at the same time incorporating into it questions on topics that had previously been covered only on periodic supplements, such as health insurance and health-related behaviors. These conflicting goals of reducing length and increasing scope were achieved in part by substantially reducing the amount of information obtained on health conditions. Inquiry was made about fewer conditions and focused on conditions with high impact on public health – those with high prevalence or high cost.

Furthermore, direct questions on specific health problems were asked only on the sample adult and sample child questionnaires. In the post-1996 NHIS family module, direct questions about specific health problems, such as mental retardation, are no longer asked, and the specific health problems about which direct questions are asked in the sample adult questionnaire do not include mental retardation or developmental disability. (Direct questions are asked in the child sample questionnaire, however.) These omissions (relative to the NHIS-D and the pre-1997 NHIS core) probably account for the major part of the underestimate of MR/DD in the year 2000 NHIS.

It is beyond the scope of this brief to examine the potential policy effects of poor measurement of MR and DD in the NHIS, but it may be noted that the MR/DD population, while small in size, accounts for 10% of all national Medicaid expenditures.

Next Steps

Assuming that the estimates of the prevalence of MR/DD from the post-1996 NHIS family questionnaire data are not acceptable for purposes of science or policy, what can be done to improve them? Broadly speaking, there are three possibilities: adding data from the adult and child sample person questionnaires (which will require aggregating several data years), adjusting the estimates based on the information currently collected in the NHIS, or increasing the quantity and quality of the information collected in the NHIS.

In this brief, the attempt to estimate MR/DD prevalence from the post-1996 NHIS was intentionally limited to the data collected in the Family Core questionnaire, because that module had the most complete information on MR/DD and also the largest sample. But there is data in both the Adult Sample Core questionnaire and the Child Sample Core questionnaire that is related to MR/DD. If that data is added to the data from the family questionnaire, a better estimate may be achieved; however, several years of data will have to be aggregated to make stable estimates. As part of the present project, new estimates using data from all three core modules – the family questionnaire and the sample adult and sample child questionnaires – was undertaken using data years 2000-2002. Those variables failed to improve the accuracy of the estimates (see Hendershot, in press, at <http://rtc.umn.edu/nhis/pubs.html> for details).

To elaborate on the second possibility, adjustments to estimates, if it were possible to estimate the prevalence of MR/DD using the restricted *operational definition of the post-1996 NHIS*, but using the relatively *rich data from the NHIS-D*, the ratio of the estimates by Larson et al. (2000) and the new estimates could be used as a “correction factor” for estimates based on the post-1996 NHIS. If the correction factors could be estimated for subgroups of the MR/DD population (by age and gender, for example) the overall adjustments would be improved. Adjustments by age and gender, however, would not correct for other response biases that might exist, such as

differences in the seriousness of impairments: Persons with relatively minor impairments may not respond because they are in assisted employment situations during the day, whereas persons with more serious impairments may be at home and available for interview.

The third general approach to improving estimates of MR/DD in the NHIS is to improve the information obtained by the survey. Making changes in the NHIS is time-consuming, administratively difficult, and very expensive. The most feasible approach to making changes would be through periodic “supplements” to the NHIS, small sets of additional questions that would be inter-woven with the core questions at intervals of several years. The additional questions would be designed to pick up the subgroups of the MR/DD population that are missed by questions in the core questionnaires. In years of the NHIS that included the supplementary MR/DD questions, accurate estimates of prevalence could be made; furthermore, those years would provide benchmarks that could be used to adjust the estimates for intervening years.

It is important to national policy and full understanding of the disability status of the nation that there be a reliable statistical program that periodically identifies with accuracy a representative sample of persons with MR and/or DD in the U.S. population. This is a population of substantial importance because its disabilities tend to be substantial, its impairments tend to be life long, and the costs for its support tend to be great. It is important that we assure the best national data feasible on this population. To that end, we plan to undertake the additional analyses described above to improve estimates and derive correction factors, or at least bias estimates, from existing data in the NHIS-D and post-1996 NHIS. Whether or not those analyses yield techniques for deriving useful estimates of MR/DD statistics, they will at least provide the detailed knowledge needed to improve NHIS data in the future. In the meantime, we intend to maintain a liaison with the NHIS staff to consider cost effective approaches to assuring adequate national statistics on MR and DD.

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Online RTC Resources

The following Research and Training Center on Community Living (RTC) research and policy publications are available online and may be of interest to readers of this *DD Data Brief*:

DD Data Brief

(<http://rtc.umn.edu/nhis/pubs.html>)

A series summarizing analyses of the 1994/1995 National Health Interview Survey Disability Supplement, conducted by the Research and Training Center on Community Living. Available are the following issues:

- Response Patterns Among Adult Respondents with Mental Retardation in the National Health Interview Survey, 1997-2002. (2004)
- Gender, Age, and Disability Differences in Functional Limitations for Non-Institutionalized Adults in the NHIS-D. (2004)
- Service Use by and Needs of Adults with Functional Limitations or ID/DD in the NHIS-D: Difference by Age, Gender, and Disability. (2003)
- Health Insurance Coverage and Health Care Experiences of Persons with Disabilities in the NHIS-D. (2003)
- Children with Disabilities: Social Roles and Family Impacts. (2002)
- Functional Limitations of Adults in the U.S. Non-Institutionalized Population. (2001)
- Demographic Characteristics of Persons with MR/DD Living in Their Own Homes or with Family Members. (2001)
- Characteristics of and Service Use by Persons with MR/DD Living in Their Own Homes or with Family Members. (2001)
- Prevalence of Mental Retardation and/or Developmental Disabilities. (2000)

Policy Research Brief

(<http://ici.umn.edu/products/newsletters.html#policy>)

A newsletter summarizing research on policy issues affecting persons with developmental disabilities. Issues summarize research on the following topics:

- Costs and Outcomes of Community Services for Persons with Intellectual and Developmental Disabilities. (2004)
- Medicaid Home and Community-Based Services: The First 20 Years. (2003)
- Wages of Direct Support Professionals Serving Persons with Intellectual and Developmental Disabilities: A Survey of State Agencies and Private Residential Provider Trade Associations. (2003)
- Alternative Schools and Students They Serve: Perceptions of State Directors of Special Education. (2003)
- Health Status, Health Care Utilization Patterns, and Health Care Outcomes of Persons with Intellectual Disabilities: A Literature Review. (2002)
- Family Support for Families of Persons with Developmental Disabilities in the U.S.: Status and Trends. (2001)
- Do We Really Mean Families for All Children? Permanency Planning for Children with Developmental Disabilities. (2000)
- "No Right is More Precious": Voting Rights and People with Intellectual and Developmental Disabilities. (2000)
- Behavioral Outcomes of Deinstitutionalization for People with Intellectual Disabilities: A Review of Studies Conducted Between 1980 and 1999. (1999)

Other NHIS-D Resources

Statistical Analyses Based on the National Health Interview Survey on Disability: A Bibliography and Summary of Findings

This annotated bibliography contains a summary of research publications based on original analyses of data from the 1994-1995 National Health Interview Survey on Disability. This bibliography describes 112 articles that were grouped in six categories: methods, assistive technology and personal assistance services, policy issues, populations of special interest, types of disability, and out of scope. Key findings are briefly summarized in each area. The bibliography can be viewed at <http://rtc.umn.edu/nhis/pubs.html>.

Fact Sheets

The *Fact Sheets* are based on the preliminary analysis of the characteristics and needs of people with mental retardation or developmental disabilities (MR/DD) from the NHIS-D. They are updated regularly as additional analyses are done. Topics include:

- Poverty Status of Non-Institutionalized People with MR/DD
- Prevalence of MR/DD in Non-Institutionalized People by Age
- Marital Status of Non-Institutionalized People
- Prevalence Estimates of ID/DD Among Young Children from the NHIS-D

The *Fact Sheets* are online at <http://rtc.umn.edu/nhis/pubs.html>

Using Survey Data to Study Disability: Results from the National Health Interview Survey on Disability

Published in 2003, this volume contains 16 chapters covering a variety of topics that add not only to our information about persons with disabilities, but also serve as a useful guide to using the extensive NHIS-D data set to address the numerous questions about the characteristics and needs of people with disabilities. For more information or to order this book, please visit http://www.elsevier.com/wps/find/bookdescription.cws_home/680759/description or call (800) 545-2522.

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